RSC Republican Study Committee
Rep. Jeb Hensarling (R-TX), Chairman
Russ Vought, Executive Director
132 Cannon House Office Building
Washington, DC 20515
www.house.gov/hensarling/rsc
ph (202) 226-9717 / fax (202) 226-1633

RSC Policy Brief: Specialty Hospitals

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In light of proposals by House Democrats to enact additional restrictions on physician-owned hospitals, the RSC has prepared the following policy brief analyzing the issue.

Background: The past few years have seen the significant growth of so-called specialty hospitals. These facilities, which generally concentrate on one medical practice area (often cardiac or orthopedic care), are often able to provide higher-quality care than general hospitals due to their focused mission. Critics of specialty hospitals claim that, by "cherry-picking" the best—and therefore most lucrative—candidates for surgical procedures, they siphon off revenues from general and community hospitals, threatening their future viability.

The ownership arrangements of many specialty hospitals have also been questioned. While federal law against physician self-referral prohibits doctors from holding an ownership stake in a particular department of a hospital facility, the "whole hospital" exemption permits physicians to hold an ownership stake in an entire facility. Because many specialty hospitals are physician-owned in whole or in part, some critics believe that physicians owning a stake in a specialty hospital may be inclined to perform additional tests and procedures on patients due to a stronger profit motive.

Legislative History: Congressional action on specialty hospitals over the past several years has focused on the "whole hospital" exemption and the issue of physician self-referral. In December 2003, Section 507 of the Medicare Modernization Act (P.L. 108-173) placed an 18-month moratorium on physician self-referrals to any new specialty hospital and ordered reports to Congress regarding the issue. Upon expiration of the moratorium in June 2005, the Centers for Medicare and Medicaid Services (CMS) issued a further suspension in the processing of Medicare enrollment applications for specialty hospitals, pending a CMS review.

In February 2006, Section 5006 of the Deficit Reduction Act (P.L. 109-171) extended the CMS suspension of applications for new specialty hospitals until CMS submitted a report to Congress.

The report, issued in August 2006, summarized the earlier reports on specialty hospitals and outlined a strategic plan for examining the issues raised. Although the report included no legislative recommendations, CMS did subsequently issue regulations in August 2007 requiring all hospitals, not just specialty hospitals, to notify patients of their physician ownership arrangements beginning in Fiscal Year 2008.

In July 2007, Section 651 of H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act, proposed several modifications to the "whole hospital" exemption for physician self-referral. Most notably, the bill applied the exemption only to those facilities with Medicare provider agreements in place prior to July 2007—excluding new specialty hospitals or other facilities, including those currently under construction, from protection under the self-referral statute—and prohibited existing facilities from expanding their number of operating rooms or beds. While the bill passed the House by a 225-204 vote, the Senate has yet to take up the measure.

Quality of Care: Many public and private studies that have examined the specialty hospital issue have compared the quality of care and patient outcomes for both specialty and general hospitals. Most studies have found that specialty hospitals perform no worse than general hospitals with respect to patient outcomes, and many studies have found measurable performance improvements. The independent quality review firm HealthGrades found that specialty hospitals constitute a disproportionate share of the highest-quality facilities among the top tier of facilities it surveyed.[1]

The focus on improved quality control comes at a time when the impact of medical errors and hospital-acquired infections has risen to greater prominence. The landmark 1999 Institute of Medicine study *To Err Is Human* estimated that between 44,000 and 98,000 Americans die annually in hospitals due to preventable medical errors, creating a total economic cost of as much as $29 billion.[2] A November 2006 report utilizing data from a new infection-reporting regime in Pennsylvania found 19,154 cases of hospital-acquired infections in 2005 alone, representing an infection incident rate of more than 1 in 100 hospitalizations, and average costs for patients who developed infections nearly six times higher than those who did not ($185,260 vs. $31,389).[3]

For this reason, many specialty hospitals include their physician-owners in all aspects of the planning, design, and implementation of the facility and its treatment delivery systems, so as to minimize the possibility of preventable errors and the spread of infection. Additionally, regular performance of surgical procedures in specialized settings permits physicians and medical staff to develop expertise and innovative techniques that improve the quality of care delivered. For instance, physicians in one cardiac specialty hospital developed new procedures to recognize and

[1] Cited in David Whelan, "Bad Medicine," *Fortune* 10 March 2008, available online at http://www.forbes.com/forbes/2008/0310/086_print.html (accessed March 1, 2008).
[2] Institute of Medicine, *To Err Is Human: Building a Safer Health System*, summary available online at http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf (accessed March 1, 2008).
[3] Pennsylvania Health Care Cost Containment Council, *Hospital Acquired Infections in Pennsylvania*, available online at http://www.phc4.org/reports/hai/05/docs/hai2005report.pdf (accessed March 1, 2008).

treat irregular heartbeats following surgery; the new protocol reduced incidence of this dangerous symptom by two-thirds.[4]

Although some critics of specialty hospitals cite concerns about "cherry-picking"—whereby physician-owned facilities attract comparatively healthy patients, leaving general hospitals to treat the sickest cases—reports such as the HealthGrades study have quantified the better care provided by many specialty hospitals on a risk-adjusted basis that controls for patients' varied health status. Some specialty hospitals have been found to have patients sicker than average when compared to Medicare claims data are used to compare patients in specialty hospitals and general hospitals.[5] Moreover, to the extent that specialty hospitals may wish to pick the "easiest" cases, such changes can be resolved by reforms currently being implemented by CMS to reform Medicare's diagnosis-related group (DRG) classification system and adjust reimbursements to more closely reflect health status upon admission.

Financial Arrangements: Much of the criticism surrounding specialty hospitals has focused on the potential conflict-of-interest associated with physician ownership, and specifically whether an ownership stake motivates physicians to increase the number and scope of tests and procedures performed, increasing patient costs. In scoring the additional restrictions proposed by Section 651 of the CHAMP Act, the Congressional Budget Office (CBO) asserted that Medicare spends more for outpatient services for patients treated in specialty hospitals than for treatments provided in other facilities. Based on this assumption and related changes in reimbursements, CBO estimated that the CHAMP Act's proposed restrictions on specialty hospitals would generate $3.5 billion in savings to the federal government over a ten-year period by diverting patient care to general and community hospitals.

However, the CBO score did not take into account any potential savings due to differential rates of medical errors and acquired infections when comparing costs in specialty and general hospitals. One study noted that the nearly 9,000 infections acquired by Medicare and Medicaid recipients hospitals during 2004 cost taxpayers nearly $1.4 billion in added costs in Pennsylvania alone—and the study also noted that hospital-acquired infections, and thus the costs associated with them, were likely to be underreported during the report's time frame.[6] Given the existing studies documenting better patient outcomes and lower infection rates in physician-owned facilities, reduced costs to the federal government from an expansion of specialty hospitals could well exceed the $3.5 billion in purported savings CBO attributes to lower utilization rates by general hospitals.

In addition, some critics of the ownership arrangements of specialty hospitals have failed to acknowledge the implications of the vast growth of hospital-owned physician networks in the past two decades. While a 2005 CMS report to Congress noted that "we did not see clear,

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[4] Regina Herzlinger and Peter Stavros, "MedCath Corporation (A)," Harvard Business School Case No. 303-041, rev. August 2006, p. 10.
[5] Regina Herzlinger and Peter Stavros, "MedCath Corporation (C)," Harvard Business School Case No. 305-097, rev. May 2006, p. 1.
[6] Pennsylvania Health Care Cost Containment Council, *Reducing Hospital-Acquired Infections: The Business Case* (Issue Brief No. 8, November 2005), available online at http://www.phc4.org/reports/researchbriefs/111705/docs/researchbrief2005report_hospacqinfections_bizcase.pdf (accessed March 1, 2008).

consistent patterns of preference for referring to specialty hospitals among physician owners relative to their peers," it also added that "physicians in general are constrained in where they refer patients by several factors."[7] Physicians working for networks affiliated with a particular community hospital may be contractually obligated to refer their patients to that hospital. When viewed from this prism, the significant growth—from 24% in 1983 to 39% in 2001—of physicians directly employed by hospitals or other medical centers is likely to have had a greater impact on physician referral patterns than the growth of approximately 200 specialty hospitals when compared to 60,000 hospitals nationwide.[8]

Conclusion: The benefits of increased specialization have been examined and analyzed by economists for more than two centuries. In his seminal work *The Wealth of Nations,* Adam Smith highlighted the benefits of a division of labor to focus on discrete tasks as providing the greatest possible improvement in productivity, and thus economic growth, for all individuals. In health care, specialization can increase productivity gains, which are the key to controlling the rise of health care costs without relying on heavy-handed rationing of care. The growth of specialty hospitals—which focus on performing discrete groups of surgical procedures well, improving quality and thus reducing costs—is consonant with the theories which Smith and his adherents used to expound open markets and free trade worldwide.

Amidst spiraling costs and uneven quality, the health sector warrants more competition, not less: new entrants to introduce innovative techniques and practices improving the quality of care; greater transparency of both price and quality information, so patients can make rational choices about the nature of their treatment options; and a funding system that reduces where possible the distortionary effects of third-party payment and empowers consumers to take control of their health. Viewed from this perspective, opposition to undue and onerous restrictions on the specialty hospitals that have driven innovation within health care may strike many conservatives as a return to first principles.

For further information on this issue see:

- *CMS Report on Specialty Hospitals*
- *Forbes Magazine Article on Specialty Hospitals*

RSC Staff Contact: Chris Jacobs, christopher.jacobs@mail.house.gov, (202) 226-8585

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[7] Department of Health and Human Services, "Study of Physician Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Modernization Act of 2003," available online at http://www.cms.hhs.gov/MLNProducts/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf (accessed March 1, 2008).

[8] Kaiser Family Foundation, *Trends and Indicators in the Health Care Marketplace*, Section Five, available online at http://www.kff.org/insurance/7031/print-sec5.cfm (accessed March 3, 2008) ; Whelan, "Bad Medicine."